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ABSTRACT

Contrasting the differences between a non-Indian child abuse/neglect center with an Indian model, this report highlights the qualities of the Urban Indian Child Resource Center (CRC) in Oakland, California. The non-Indian concept of the cause of child abuse/neglect, based on the abused/neglected childhood of the parent, is compared to the Indian concept of the cause as being institutional abuse, defined as social institutions in one culture abusing whole segments or classes of persons in another society. Based on the Indian idea of family, CRC's structure includes the normal positions, but also the Family Support Network, licensed foster placements: Homemakers, Indian women providing important links between CRC and the Indian community: and Family Representatives, Indians with formal training as mental health workers. Clients come from many tribal backgrounds and have large families, but few financial and emotional resources. Activities of staff members, mainly intervention and prevention, are detailed along with examples and composite case histories. Six tables show the success rate to be 61.3%. Brief comparisons are made between CRC and four other Indian centers. Concluding the report are seven recommendations, the first of which "cannot be overemphasized". Control of Indian programs must be in the hands of Indians. (AN)

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A MODEL FOR TREATMENT IN A NATIVE AMERICAN FAMILY SERVICE CENTER

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Prepared for

Urban Indian Child Resource Center
Oakland, California

December 1978

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PREFACE

This report contains the story of many dedicated and hardworking people; without them and without the funds from the National Center on Child Abuse and Neglect, this story could not have been told. Special thanks are due to Betty Newbreast, whose knowledge and caring contributed more to this effort than any numbers in tables can ever quite express. Jennie Joe's faith gave everyone the assurance to keep going. Rosie Irwin's valient labor on her "scrolls" produced the basic information which the project needed. Joan Hiltner has never seen the Center or its people, but without her sensitive and patient work, the story would never have been committed to print so that others could read it.

TABLE OF CONTENTS

	PREFACE	iv.
	LIST OF TABLES	vi.
I.	INTRODUCTION	2
II.	THE PROBLEM AND ITS CAUSE	4
III.	HOW THE CENTER IS ORGANIZED	16
IV.	THE PEOPLE WHO USE THE CENTER	32
V.	WHAT THE CENTER DOES	48
VI.	HOW WELL THE MODEL WORKS	64
VII.	OTHER SETTINGS, OTHER PROGRAMS	73
VIII.	RECOMMENDATIONS	82
	LIST OF REFERENCES	87

LIST OF TABLES

Table 1
Type of Crisis Categories Reported For 194 Cases Seen Before June 1978 40

Table 2
Crisis at Referral by Source of Referral for 194 Cases 42

Table 3
Type of Service Offered by Crisis-at-Referral For 194 Cases Closed as of June 1978 44

Table 4
Distribution of Closed Cases By Crisis at Referral and Outcome 67

Table 5
Distribution of Closed Cases By Type of Service and Outcome 68

Table 6
Distribution of Closed Cases Involving Placement and/or Family Stabilization By Outcome 69

Table 7
Distribution of Closed Cases Involving Short-Term Services By Outcome 70

Table 8
Distribution of Closed Cases Involving Referral and Resource Coordination By Outcome 71

Table 9
Distribution of Closed Cases Involving Services to Adolescents By Outcome 72

I. INTRODUCTION

The Urban Indian Child Resource Center (CRC) in Oakland, California was the first urban Indian project funded by the National Center on Child Abuse and Neglect (NCCAN). The proposal under which it began operations in 1975 called for a staff of Family Representatives who were to act as advocates for Indian children and their families. According to the proposal:

> It is not the intent of the Center to provide services itself, but rather to coordinate existing services appropriately. For example, Family Representatives will not be charged with conducting family therapy, but will be expected to be familiar with those public and private agencies which do conduct family therapy (UICRC 1974:11).

Over the course of its first two years of existence, the Center moved from its initial goals, narrowed its scope of services, and by its own admission, switched from resource coordination to treatment. However, the type of treatment offered by CRC does not conform to the usual expectations of a therapeutic model. What has happened at the Center is the growth and development of a new model, based on antecedents from traditional Native American cultures and the realities of contemporary Native American existence as experienced and understood by Native Americans themselves. In other words, the Urban Indian Child Resource Center has "grown its own."

The Center, like all NCCAN-funded demonstration projects, was subject to a mandated evaluation which was contracted to a private consulting firm. The list of service delivery categories, which these outside evaluators used to code the activities of the CRC staff, reveal elements of a treatment model familiar to most health professionals, therapists, and social workers. The list contains activity codes which assume that treatment consists of diagnosis, through expert investigation of client symptomology such as personality, social status, and behavior; intervention via activities performed by professional staff (sometimes with the assistance of nonprofessionals under professional guidance) to be done to or for clients; support services not considered to be therapeutic but rather auxiliary in nature, such as homemaking, transportation, coordination, and resource referral; prevention, in the form of community awareness campaigns or special programs for persons designated "high risk," and administration, which includes the structure within which staff and their activities are managed. A sixth category, which was not involved directly in the evaluation codes, but which is usually implicit in most theoretical explications of treatment models, is etiology, the developmental sequence of the condition being treated.

From the beginning of the program, CRC staff has labored valiantly to code their activities into the categories derived by the evaluators. However, it has become clear that what they actually do and what the codes imply they should do are very different. By analyzing the Center's own use of such concepts as etiology, prevention, diagnosis, support services, administration, and intervention, the Indian treatment model can be seen.

Initially, the plan was to organize this report according to the elements just outlined, so as to contrast the Center's model with that found in most non-Indian settings. However, Center activities and structure do not easily lend themselves to such analysis, and to force them into the non-Indian mold is to lose much of the dynamic qualities which they possess. Therefore this report is organized so as to highlight CRC's qualities; comparisons are made with the more familiar non-Indian model as appropriate to the narrative. The intention is to let the Center tell its own story in its own way.

The sections in the report begin with an explanation of the problem and its causes, as seen from an Indian perspective. The next section describes how the Center is structured. Following that is an overview of the families who come to the Center for help. A description of Center activities can be found in Section V, and an analysis of how well it works is in Section VI. Comparisons with other Indian programs are in Section VII. An overall summary with recommendations concludes the report.

II. THE PROBLEM AND ITS CAUSES

In order to establish an effective treatment program, it is necessary to know the nature of the problem to be treated and how it developed in the first place. In the Anglo medical model of disease, knowledge about the causes and development of a problem is called etiology. It is at the etiological level that the major difference between an Indian and a non-Indian model can be seen, because from etiology the other elements of a model are derived. This section of the report contains a comparison of the way most experts in child abuse/neglect view the root causes of the problem, with the way that Indians define the problem and its developmental sequence.

At the base of the two models is a distinction between individual pathology on the one hand and institutional process on the other. The former model--the non-Indian one--assumes that child abuse/neglect begins and develops within the context of personal experience and individual growth and development. The latter--the Indian model--sees the problem as due to social processes originating outside the individual and occurring because of institutional pressures exerted by one society on another cultural system.

This section begins with a brief overview of the non-Indian concept of the etiology of child abuse/neglect. Contrasts between Indian and non-Indian childrearing patterns provide a background for

understanding the Indian view of etiology and the impact of institutional abuse/neglect on contemporary Indian children. Once the institutional concept of etiology is clearly understood, then the other elements of the model fall neatly into place.

In the non-Indian child abuse/neglect model, investigators have looked for the etiology of the problem in the life histories of abusive and neglectful parents. What kind of people are the parents? What makes them hurt their children? Why have they not developed a sense of responsibility for their children's wellbeing? What would cause a parent to harm his/her own child?

In general, studies have focused first on the personal characteristics of the parents and then on the conditions under which the parents spent their own childhood. From clinical experience and research which compares abusive parents with nonabusive parents, several characteristics or constellations of factors have been identified as being more prevalent among parents who abuse or neglect their children than among those who do not. The following is a list of such characteristics as outlined by a prominent expert in this field (Steele 1975:4):

--A special form of immaturity and associated dependency.

--A tragically low self-esteem and a sense of incompetence.

--Difficulty in seeking pleasure and finding satisfaction in the adult world.

--Social isolation and a reluctance to seek help.

--Fear of spoiling infants and a strong belief in the values of punishment.

--Misperceptions of the infant's abilities (role reversal).

--Lack of empathy for the infant's needs.

The caseworkers at CRC would agree that many of the parents they work with share some of the above characteristics with the abusive parents from which the list was derived. Where they disagree with most experts is in the explanation of why the parents have these characteristics. Most non-Indian clinicians and researchers look to the experiences which the abusive parents had when they were children. The conclusion, which has become a virtual cliché, is that these parents were themselves abused or neglected by their parents. For example, Steele notes that in order to work effectively with these parents, one must

> ...realize that one is not working with an abusive parent as much as one is working with a grownup person who was in his own early life a neglected or abused child himself....For most abusive parents their immaturity and dependency is essentially functional in nature and related to the emotional deprivation endured in early life (1975:4).

Steele goes on to detail how such early deprivation created in the parents a lack of trust or hope in the future. They have, he says, "no storehouse of spare emotional energy" (p. 5). Thus, the root causes of child abuse and neglect are thought by most experts to be found in the ways in which the grandparents deprived and abused the parents. In other words, the search for the etiology of child abuse/neglect begins and ends with individual life histories and interpersonal dynamics within a nuclear family.

However, the Indian caseworkers at CRC see the causal chain differently. They agree that the Indian parents suffered abuse and

neglect early in their lives, but they emphatically disagree that the Indian grandparents are to blame. They cite the disruption in Indian families caused by Anglo institutions as the culprit. That is, as Anglo institutions encroached more and more on Indian family life, the effects on Indian children became more and more disruptive.

A comparison of the way families in tribal societies traditionally function with the ways most Anglo families function can help us understand more about the process. What follows is a brief overview of Indian childrearing, and for more detail the reader is referred to Joseph et al. (1949), Leighton and Kluckholm (1948), McGregor (1946), Thompson and Joseph (1945), and Morey and Gilliam (1974).

In most tribal situations, parents are rarely expected to take on the sole responsibility for childrearing. Usually, groups of siblings or cousins live close together--either under the same roof or within easy walking distance of one another. Elders usually reside with their grownup children and the entire group--parents, aunts, uncles, grandparents, etc.--are considered to share the responsibilities of raising all the children in the extended family group. In many tribal languages, the terms used to refer to relatives reflect these close ties. For example, the word in many languages which translates as "aunt" in English, really means "second mother" or "other mother."

It is not unusual for children to move from one nuclear family to another. Sometimes it happens because the child's parents have too few resources; sometimes it happens because "uncle" needs an extra hand, sometimes it is because special ties of affection have developed with "auntie." Children's wishes about where they live or with whom

in this extended family circle are usually respected in most tribal traditions.

Young parents, in a tribally based system, can count on getting as much help, support, and advice as they need. They are not usually expected to make all parenting decisions alone; they are rarely expected to make the abrupt transition from nonparent to parent status that is often required of young Anglo parents. When an Indian baby is born, the parents do not lose their own status as child to the grandparents or niece/nephew to their aunts and uncles. These respected elders are there to help without imposing expectations beyond the parents' experience. In turn, the young parents maintain a sense of respect and deference for the experience and wisdom of the elders.

Contrast this tribal experience with the expectations in Anglo culture. Young adults usually live separate from their extended families. They make an abrupt change in status when the first baby is born. They are expected to take sole responsibility for the care and character development of their children. This value of individual responsibility makes it easy for non-Indian social workers to view a child who is living with someone other than his/her natural parents as having been abandoned by those parents.

In contrast to Indian parents, Anglos, when they do seek assistance, seek it from experts--the pediatrician, the teacher, the family counselor, or one of the myriad books on parenting. They are not expected to go to their own parents and are often encouraged to follow more "modern" or "scientific" methods than their parents used. The experts, then, have little difficulty in believing that they know better than the parents what is good for a child.

In Anglo culture there is an expectation of change from generation to generation, whereas in most Indian cultures there is an expectation that the generations will repeat themselves. This value that change--progress--is necessary and desirable makes it easy for Anglo teachers and social workers to see the removal of Indian children from their homes as in the best interest of the child, or to view acculturation to a technological way of life as a laudable goal.

The result, as workers at CRC point out, is that the life histories of parents seen at the Center show an extremely high rate of separation from their natal families due to foster placement and boarding school education. These parents were removed from their homes at an early age and placed in non-Indian settings. Many began life with what child development experts call "empathic mothering," but their bonds with their families were destroyed through outside interference.

What happened is that ethnocentrically-bound social workers, Christian missionaries, Anglo schoolteachers, and court officials--some well-meaning and some not so well-meaning--have caused the widespread destruction of Indian families. For example, on a national level, twice as many Indian as non-Indian children are annually placed in foster care--virtually all in non-Indian homes (Center for the Study of Social Welfare, 1976). Indian children are the only normal children in the U.S. (i.e., children not stigmatized by physical or mental disabilities) who are routinely institutionalized. These are the children, many as young as 5 years old, who are kept from their families for at least 9 months out of the year while residing in dormitories and attending Anglo-run boarding schools (BIA, 1976; Metcalf, 1976).

If we trace out the effects of educational, social, and institutional policies on Indian children, we can see how they lead to the problems seen by the caseworkers at CRC. Let's take the characteristics which Steele listed as common to abusive/neglectful parents. For Indian clients, it can be shown in each case that these characteristics developed because of institutional abuse/neglect.

To begin with, Indian children who were removed from their homes to go to boarding school were denied an opportunity to model nurturance and appropriate parenting behavior. Two of the characteristics listed by Steele--misperceptions of an infant's abilities and the resulting lack of empathy for an infant's needs--can thus be explained by the lack of experience within a family which many Indian children have suffered because of boarding school.

In the case of fear of spoiling children and a belief in punishment, it can be shown that those values came not from traditional Indian childrearing patterns, but from experience in Anglo boarding schools, where discipline was rigid and the atmosphere regimented. Most tribal patterns emphasize a learn-by-imitation approach. Anglo observers often misinterpret such an approach and label it "permissive," by which they usually mean "neglectful." In actuality, it is anything but. Children are shown respect for their abilities and are given no expectations beyond those abilities. As pointed out above, in tribal societies there is usually a wide circle of adults nearby, watching over the children and providing assistance when asked. Few direct demands are made upon a child, and few commands given. The desire to imitate and please one's elders motivates the child to learn and develop.

It was in school that many of these children first encountered spanking, harsh commands, expectations beyond their capacity to perform, and punishment for failure. They began to doubt their abilities, and because they were after all only children, they began to apply the negative messages coming at them to their perceptions of themselves. The result was the tragically low self-esteem Steele noted, and the lack of a sense of competence.

Even when the parents grew up on the reservation and lived at home, they nonetheless spent years in Anglo-run schools where they were told through textbooks and by teachers that their ancestors were savages who stood in the way of progress, that their religions were pagan superstitions, that their languages were inadequate for the modern world, that their homes were dirty, squalid, and unsanitary. The Anglo teachers and non-Indian foster parents urged them to turn their backs on the "old ways," give up their "superstitions," and instead learn English, become Christians, and strive for success in an Anglo world.

To children, negative messages are more powerful than positive ones, so that "don't be Indian" was more devastating to self-esteem than the positive message, "be Anglo." Besides, it did not take long for the children to learn that it is very difficult for a non-Anglo to become successful in an Anglo world, even if one works hard and speaks good English. A complete recitation of statistics relating to the socioeconomic status of Indians in the United States is beyond the scope of this report. Suffice it to say that they are the least well-educated, the most unemployed, the least healthy, the most ill-housed of any group in this country (cf., U.S. Office of Special Concerns, 1974; U.S. Census Bureau, 1970).

Literature on Native Americans contains volumes of arguments advanced by anthropologists, educators, historians, activists, and others about the relative importance of such processes as culture-conflict, economic oppression, colonization, and racial prejudice in explaining this state of affairs (cf., Bahr, Chadwick, and Day 1972; Jorgensen 1970; Metcalf 1978). Rather than summarize these arguments, let us take a look at the realities from a child's point of view. On the one hand, the child is told to give up being Indian and become like Anglos, and on the other hand the child can see that Anglo society discriminates against Indians. Like the young Black children Goodman (1964) studied, Indian children become aware very early about the generally negative stereotypes applied to non-Anglos in the United States. The child is faced with a choice that few adults are capable of making--to remain Indian is to face a future that looks bleak and doomed to economic failure, but to turn one's back on one's heritage is to turn against one's parents and one's identity.

Furthermore, the structure of most Anglo institutions make it seem impossible for a person to be <u>both</u> Indian and successful. Only very recently in U.S. history has there been a recognition that non-Anglo heritage is worthy of respect and dignity. For the most part this belated recognition--which came about because of protests from non-Anglos and not because Anglo society as a whole initiated it--was not around when the parents at CRC were growing up. What they saw as children in the 1950s and early 1960s was overt racism practiced by the citizens who live in the small Anglo communities which surround their reservations and exploit their resources. Later, when these children as young adults moved into the cities, they experienced

further evidence of racism--not only from Anglos but also from other ethnic groups in whose ghettos the Indians were forced to settle. Their lack of trust in the future and their difficulty in finding satisfaction in the adult world are not surprising, given this state of affairs.

The dependency and immaturity result from a long history of existence in a wardship relationship. Whole societies of people have been treated as if they were incompetent children, unable to own their own resources, conduct their own affairs, pursue their own livelihood, and dispose of their own property without the express permission and intervention of BIA officials. For example, the schools the parents attended when they were children were not run by a school board elected by the community the way all other public schools in this country are. Instead, until very recently, all Indian schools have been run by the federal government "for" the Indians. What went into the curriculum, who taught the classes, where and when the schools were to run, were all decisions made for the Indians.

Without the ability to own and allocate their resources, tribes had to depend on the BIA. With no opportunity to practice self-reliance, whole communities became dependent on Anglo bureaucracy to meet their survival needs. Children growing up in these communities learn that no matter what they achieve in school or in tribal life, they can look forward to having little control over their own destinies. Since they are treated as dependent wards, they begin to take on this definition and live it.

All of this is not to say that non-Indian teachers, social workers, or foster parents are uniformly bigoted or insensitive. Many

were and are caring individuals who are truly fond of the Indian children entrusted to their care, and who respect the traditions in which they were raised. But the fact remains--and the children were very much aware of it when they were growing up--that opportunities for Indians are severely limited in the Anglo world. No matter how well-intentioned individual Anglos are or were, the society as a whole is not prepared to accept non-Anglos as full-fledged members. Based on an historical study of Indian and White transculturalization, the noted anthropologist Hallowell put it this way:

> ...it is obvious that not all socio-cultural systems are equally receptive to the assimilation of alien individuals, and the degree of receptivity of a culture depends not primarily on individual good will or ill will, but on social values and attitudes, and on institutions to mediate the induction of alien individuals into it (Hallowell 1972:215, emphasis in the original).

In summary, then, if we look to individual dynamics in individual Indian families for the cause of the problem, we cannot see the importance of the social factors. The Indian grandparents were not the ones who neglected or abused the parents; rather, the problems arose because of social institutions in Anglo society. For these reasons, CRC has labeled the problem as "institutional abuse/neglect."

The term "institutional abuse" is not original with the Center, of course; but when they use it, it differs somewhat from what others mean when they use the term. Usually institutional abuse refers to such things as beating prisoners, doing psychosurgery on inmates in mental hospitals, and neglecting to provide for the aged in nursing homes. Some of the instances of institutional abuse which were

practiced against the Indian parents come under this definition. For example, several report that they were punished in boarding school when they were caught speaking their native language by having their mouths washed out with soap. But experience at the Center indicates a broader definition is in order, namely that major institutions in Anglo society, such as bureaucracies, churches, schools, have set out deliberately to alter or destroy major institutions in Indian society. What is going on, then, is not a case of abuse against an individual who happens to be in a physical institution. Rather, it is a case of social institutions in one culture abusing whole segments or classes of persons in another society.

III. HOW THE CENTER IS ORGANIZED

Once the concept of institutional abuse/neglect is clearly understood, then the Center's approach to treatment falls logically into place. This section describes the structure of the Center and its underlying rationale. Each element within the overall system developed as a response to institutional abuse; each has utilized concepts and structures found in most tribal traditions. The way in which the people who make up the Center are organized, and the structure in which they operate, contrasts with what is usually found in Anglo systems.

In a non-Indian model, the structure is such that individual experts treat individual clients. Authority, responsibility, and service go in a unidirectional flow--from the top down; that is, the structure of the treatment setting is hierarchical. Where groups are used, they are usually homogeneous, such as Parents Anonymous (groups of clients) or multidisciplinary teams (groups of experts). Rarely are groups found composed of both experts and clients interacting on an equal footing.

An organizational chart of CRC reveals a structure common to most agencies: there is a board of directors to whom the Executive Director reports. Serving under the Executive Director is the Casework Supervisor, who is responsible for coordinating the activities of the Family Representatives and the Homemakers. Other

staff--clerical, maintenance, non-NCCAN funded projects--have an administrative structure which maps out similarly on a chart.

However, it would be a mistake to interpret the chart literally. The structure of the Center is based on an Indian concept of family--that large interconnected social network which forms the basis of tribal society. In order to see the distinction clearly, it is necessary to begin with a look at people who are not employed by the Center and who do not have offices in the Center's building. These are the people in the Family Support Network, and this discussion of Center organization begins with them.

The Family Support Network

When the Indian Nurses of California first proposed the Child Resource Center, they realized that Indian families who were already located in the city had been vitally instrumental in giving assistance to incoming Indian families on an informal and personal level. Therefore CRC set out to identify these families to do one or both of the following tasks: 1) be officially licensed and designated as foster placements for Indian children for whom there were no alternative caretaking or residential arrangements, and 2) be designated as volunteer "host" families.

The task was facilitated by the Indian "grapevine." When Indian families in the Bay Area Indian community heard about the Child Resource Center, the Center was flooded with calls from Indian parents wanting to help care for Indian children in crisis situations. Up to the formation of CRC, there were no licensed Indian homes, and Anglo social service agencies maintained that they could not recruit Indian

homes for Indian children. However, the experience of the "grapevine" demonstrates how important it is for Indians to generate their own support systems; there were families willing to take care of children so that the parents could take a break for a few days in order to become more situated. Part of the job of CRC, then, was to formulate these volunteers into a coordinated network.

The Indian family support system in the city is based on and grew out of the extended-family tradition inherent in most Native American groups. The problem for most Indian families attempting to make a rural-to-urban transition is that the extended-family system is broken. Relatives are left at home or, if there are relatives in the city, Anglo customs and housing laws are such that large groups of people are not welcomed under one roof. In addition, due to BIA Relocation policies, Native American peoples do not usually settle into enclaves or Indian neighborhoods. They are usually found dispersed throughout various locales over the metropolitan areas. Despite the potential for isolation of Indian families due to such physical separation, most Indian people living in the city feel strongly that they should help each other. Tribal groups and customs are recognized and appreciated, but the concern for helping out another Indian person goes far beyond tribal lines. The problem before the Center started was that there was no easy way to link individual families together.

The Indian families who make up the Family Support Network (FSN) do not constitute a homogeneous group; they have many different characteristics which divide the families into various categories. About one-third do not participate in powwows, an activity that on the

surface is usually associated with an "Indian identity." Many of these families have been in the urban area for some time, and often their children are no longer young. The key, however, for understanding these families' concern for Indian children (as is true among the other families of the Family Support Network) is a strong sense of being Indian and feeling good about it. This notion of "Indianness" goes beyond overt behavioral categories such as going to powwows.

A second group of families in the Family Support Network are those that have more recently suffered greatly in adapting to the urban environment. They maintained and survived because of a strong sense of family unity, are now on firm ground and want to help make it a little easier for other Indian people who are in the same situation they once faced. Often these families who are now helping used the Family Support Network themselves at one time. When they became stable, they in turn offered to become a part of the Family Support Network.

The last group of families that make up the Family Support Network are those that are new to the city. Whether their present situation is "stable" or not, they have a strong sense of the traditional importance of the family in their respective tribal groups and among Indian peoples as a whole. Because they do not have relatives and close friends in the urban area, they want to be with other Indian people and help where they can.

It is not always easy to recruit FSN families and foster parents, however. Many families do not wish to go through the myriad of bureaucratic steps to become licensed foster homes. Often the

strongest impetus for an Indian family to become licensed is that they have been volunteer FSN parents where the children's family did not stabilize. That the only remaining alternative was to turn the children over to the county spurred these volunteer families to become licensed foster homes.

Some Indian families do not want to become part of the Family Support Network. The CRC recognizes the major responsibilities involved in taking on the care of a child or children even for a few days. It has been suggested by some CRC staff that, were they to probe the background of these families, such would show that the parents were among those Indians raised in foster homes, non-Indian homes, grew up in boarding schools, and/or left home at a very early age. In sum, the element of the strong extended family would probably not be an influential part of these parents' background. Such a hypothesis deserves futher scrutiny. Nonetheless, these families do help out in other ways. They often partake in the CRC events at Christmas, Thanksgiving, Easter, and July 4th. The Family Support Network, then, is not only all those families who provide homes. It is also composed of Indian people and Indian families who help out with the various CRC functions.

In March of 1978, the Family Support Network contained 69 Indian homes in the San Francisco Bay area. Twelve of these homes had been fully licensed as foster homes, and 8 were identified as ready and willing to go through that process. Twenty-one families were active participants in the informal network and were available for short-term emergency placements. Twenty-eight additional homes had been

identified as prospective foster homes and were being actively recruited into the full range of CRC activities.

Homemakers

Homemaker services are provided as part of the case plan to CRC clients by women who are Indian and members of the Oakland Indian community. Rather than being auxiliary personnel, as they are often viewed in non-Indian programs, the Homemakers at CRC are among the most important service providers. They provide links between CRC and the Indian community as a whole, between the local Indian support network and the urban setting, between CRC and the individual family, between the Indian community and the family, between foster parents and natural parents, and between the parent and child within that family.

Each Homemaker herself has experienced the hardships of adjusting to city life while raising a family, and that fact is one of the major reasons she has been selected for the role. Having faced the problems of adjusting to the urban environment herself, she can truly identify with her clients.

She is a member of the Indian community; she has remained a part of that community even while acting as a paraprofessional operating from an "institutional" setting. As both a member of the Indian community and a staff person at CRC, she fills the role of a female relative to the client. These homemakers have the respect of the Indian community because of their experience in raising their own children, and they have the warmth necessary to teach struggling families parenting skills and survival strategies.

The Homemakers often provide a kind of respite-in-crisis to client families by relieving socially isolated parents of constant childcare duties, grocery shopping tasks, housecleaning, and budgeting. They prepare meals, assist in household management, or just stop by regularly to visit and help around the house. Often they help simply by giving a child and/or parent the warmth, nurturance, and support so needed to one in an unfamiliar and unknown environment.

Another vital attribute of the Homemaker is the fact that she has direct access to the "Indian grapevine." She either knows, or knows someone who does know, how to get in touch with any given member of the community within a few days. She either speaks, or knows someone who does speak, nearly every tribal language. This situation facilitates quick communication and thus leads to a more rapid solution to a crisis than is true of the hierarchical Anglo social worker-client relationship.

Due to the close relationship between Homemaker and client, however, certain problems can and do arise. Often it is difficult for a Homemaker to remain nonjudgmental in assessing her clients' problems. Because Homemakers are so immediately accessible, they sometimes identify with the complaints of the clients closest to them, especially the complaints of women against their husbands or sons. Thus their greatest strength, that of close alliance with the family, can sometimes become a weakness. Usually the Family Representatives can help in circumventing these potential conflicts, as can members of the Family Support Network.

A more recent occurrence that may be seen as a problem is an apparent trend toward professionalization of the Homemaker role. Via

training programs, Homemakers have been adopting the more formal terminology of the professional mental health technician. Friends, neighbors, and even relatives may be termed as "clients" and "patients." Homemakers have been found to discuss what is "best" for the client rather than allowing the client the respect to choose from a number of alternatives. Whether or not this situation is an inevitable is not yet clear.

The Family Representatives

The responsibility of individual case management and coordination falls to the Family Representatives. Each of them is Indian, and each has successfully made the reservation-to-city transition. They come from different tribal backgrounds, and like the Homemakers, are plugged into the Indian "grapevine." The Family Representatives received formal training as mental health workers at a nearby community college. Their unique combination of Indian heritage and professional training makes them a valuable asset to Center activities.

As a case comes in to the Center, it is assigned to one of the Family Representatives who, together with the Casework Supervisor, develops a case plan. At first glance, this process seems identical to that found in any social service agency; however, close scrutiny shows some major differences. In the first place, most of the work which the Family Representatives do takes place outside the Center. They visit families in their homes, instead of making appointments for the families to come to them. They spend much of their time coordinating with other agencies, both to facilitate the delivery of

services to their clients, and to educate and sensitize the other agency personnel about the special needs of Indian people.

Initially, there were five Family Representatives. They had developed a very close, mutually supportive relationship when they went through their training program together. As the inevitable strains of working with families in trouble ("burnout," it is usually called) hit them, they learned to apply to themselves what they were advocating to their clients. They became a "family" and used each other for the support and caring they needed.

At first, each Family Representative did much the same things as the others. However, they gradually developed unique and specialized functions. For example, one took over the responsibilities of casework supervision, one became the coordinator of the Family Support Network, one handled most of the teenagers. These evolving specializations tapped the particular qualities of each Representative so that his/her best talents were used.

Recently, the Center is undergoing still more changes in Family Representative roles. New workers have joined the staff; some of the original people have left; new positions have been added.

As the Center expands its activities, undertakes new projects, and extends its functions, we can expect more evolution in the role of Family Representatives. But the underlying qualities of the people occupying the positions will undoubtedly remain, as will their basic function as advocate for Indian children and their families.

Executive Director

The function of the Executive Director is to coordinate Center activities in a fashion similar to non-Indian agencies. But in addition to that, the Director must provide the link between the Center and the non-Indian world. The position is a particularly stressful one, demanding as it does dual participation in both the Indian and the non-Indian communities.

Because of the constant pressure to seek funding, the Director has had to spend an inordinate amount of time meeting the priorities of other agencies--i.e., those who give out money--and has often had little energy to spare to meet the internal administration needs of CRC.

Such pressures and strains have taken their toll and constitute yet another example of institutional abuse. More than any other agency, a newly constituted innovative program needs to be sheltered from the vagaries and whims of funding cycles. Yet these are the very programs which are most at risk when policies shift and funds run out.

To help allay some of this pressure, the Center has, over the years, developed its own network of non-Indian "helpers." These are professionals who are sympathetic to the Center's philosophy and capable of translating the Center's needs to non-Indians. These people, informally constituted as an Advisory Committee, help in mapping strategies, writing proposals, contacting influential people, and in general advocating for the Center.

Contrast this situation with that commonly applied in non-Indian models. Agency personnel, the experts, design programs for a "target" population. Usually the target population is poor and politically

impotent. The experts put together an advisory board of persons from the target population who are to provide "input" and "feedback" to the experts. Control of the program remains firmly in the hands of the experts, who can choose to acknowledge or ignore the input from the advisory committee at will. In cases of disagreement between the committee and the experts, the experts hold the power.

In the Center's case, experts provide "input" to the "target" population, which has ultimate control over whether it will or will not follow the experts' advice. This basic principle of consumer control is yet another way in which CRC is combating institution abuse/neglect. For, instead of Indians being in the position of advisers to persons who want to "help" them, CRC has reversed these roles and uses helpers who are advisory to the Indians.

Administration

A descriptive outline of the people at CRC does not fully explain how they function together. Another contrast between Indian and non-Indian models can be seen in CRC's administration and decision-making process. Staff meetings, held on a regular monthly basis, initially were attended by all staff regardless of rank or function. The chair and the recorder were rotated so that control and interpretation of decisions were never in the same hands each time. Utilizing a tribal precedent, decisions were arrived at consensually, so that all staff were represented in all action taken. When board meetings were called, any staff who wished to do so could be present and were encouraged to take part in the proceedings. Recent expansion of CRC activities has made such a process unwieldy; however, within each unit the same principles are applied.

A close look at the administration of case supervision epitomizes the nonhierarchical and tribal view of administration which was present from the beginning in the underlying philosophy of the Center. When supervision was first instituted (it was not written into the initial proposal), the intent was for the Supervisor to discuss cases with each Family Representative and assist in developing case plans. What became clear rapidly was that it was more important to deal with the caseworker's own feelings. As the Supervisor put it: "I must be able to listen to the worker's stress and help the worker cope." So supervision became an equal balance of the Family Representative's own time, on the one hand, and case management on the other. As time went on, supervision moved further and further from dictating case plans or monitoring worker activities. Rather, responsibility for case management rested with the worker, and the supervisor's role became one of support or critical review.

Under the social network mode of treatment, CRC as an entity and supervision as a function can be seen as part of a "family" system, where each member takes specific responsibilities and no one member shoulders it all. Workers gain support from each other and the Supervisor as they gradually move to draw their clients into an interdependent network. In actual cases, this process involves giving the client family more and more responsibility and linking them with the Family Support Network and the community at large.

Supervision thus is a way of helping Family Representatives shoulder and share their responsibilities, while at the same time providing a model for moving clients into an interdependent, mutually reinforcing network. The Supervisor in turn expects support and

assistance from other places in the system so that the tribal concept of community responsibility and nonhierarchical authority is extended to the agency staff as well as to the client.

As the agency became larger and new components were added, the original nonhierarchical structure began to change. The change has put strains on the system and indicates an area of concern and a place to move cautiously for programs which seek to emulate CRC. The primary stress appears to originate outside the system as pressures from funding agencies and other regulatory bureaucracies impose more and more restrictions on the Center's autonomy.

The Potlucks and The Grapevine

In order to understand the Indian specific nature of the kind of intervention offered at CRC through the Family Support Network, homemaking service, case coordination, and foster placement programs, it is necessary to look at how these programs are carried out.

Much of the work involved takes place in and around events such as potlucks, powwows, feasts, and recreation programs. What to an outsider may look like pleasant social gatherings--full of fun and little work--are to CRC staff examples of an important treatment mode. These are occasions for building ethnic identity, solidifying families, gaining spiritual guidance through traditional songs and ceremonies, educating children, and in general breaking through patterns of social isolation.

In structure, such events are nonhierarchical; staff, professionals from other Indian organizations, clients, foster parents, natural parents, children, and adults all participate on an equal

footing. It would be a mistake to assume that these treatment modes constitute what some anthropologists contemptuously call "back to the blanket." The object is not a nostalgic return to patterns derived from other times and other places. Rather, the ideal is to provide a warm positive Indian environment for Indian children in contemporary society.

The Child Resource Center is instrumental in providing a center where families can meet and come together from time to time for mutual support and an enjoyable time. No matter what it is termed, however, the Family Support Network is common to all urban Indian communities. It is an Indian family way of functioning. In the words of a Child Resource Center staff member:

> We've started a nurturing base that could help people. The family support network is a mental health [system]. When Indian people get lost in the city or lost in the urban setting, what they need is to acquaint themselves with and have access to people of their own kind. Indian families have stabilized and hang onto their Indian ways. They still survive in the urban setting. With the family support network you're connecting [the person in crisis] back to a strong [traditional] link--the extended family--that would help him. I was talking about mental health. That's making a person feel really good about, that there's something really positive to being part of an Indian family.

A word is in order about the "grapevine." This is an informal word-of-the-month communication network. Through it news travels of events which are important to Indians, of information about jobs, services, and various opportunities. Messages are sent between relatives or friends; tabs are kept on the comings and goings of families.

There is a tendency for Indians to place more reliance on this face-to-face means of disseminating news than on more formal forms of

written communication such as newsletters or mailed notices. Perhaps the preference for the "grapevine" is linked to the precedence in tribally-based oral traditions; perhaps the written word is too impersonal to engender trust; or, more likely, perhaps a combination of these factors is at work. In any case, the "grapevine" is the single most important communication network available to Indians. Messages can flow through it with astounding rapidity.

There are identifiable people in the network who serve as nodes or "switchboards." They seemed to attract information and maintain contact with large members of persons to whom to pass it on. The Center has such people on its staff and has made excellent use of their abilities in order to obtain resources for the clients.

Another use which is made of the "grapevine" is as a social control mechanism. Traditional tribal cultures have often used teasing and shaming as a means to control behavior which did not live up to cultural standards. Fear of being talked about and having one's weakness exposed to public scrutiny is a powerful deterrent. Of course, unfounded rumors and gossip sometimes flow through the "grapevine" as well as trustworthy pieces of information. Usually the persons at the nodes are able to intercept these and reverse their effect rapidly.

This system is probably not amenable to formal organization. It is the informality of person-to-person links which give the system its vitality and effectiveness.

Summary

The organization of the Child Resource Center reflects the basic Indian concept of family. In structure and functions it is a large, interconnected social network. Since the root cause of the problem is seen to be in the destruction of Indian families, then the solution is logically seen as the reconstitution of such a family system. And, for CRC, that reconstitution begins with the organization of the Center itself.

In such a family-based system, rigidly hierarchical chains of responsibility have little place. Nor do such concepts as "impersonal interaction," "objective assessment," or "professional distance." A tribal family functions as an interdependent unit where responsibility is shared. In an Indian model, structure and function are not easy to separate into neatly defined elements. For, a family-based treatment approach requires a family-based organization.

IV. THE PEOPLE WHO USE THE CENTER

This section contains a description of the people who use the Center--the clients whom the Center was designed to serve. Their basic characteristics will be described, along with an analysis of how they got to the Center and why. In order to provide a basis for a more detailed analysis of CRC activities, which will be found in Section V of this report, a composite case history typology is presented. As will be seen, this presentation of client characteristics differs from that in a non-Indian model, which relies on formalized diagnostic procedures.

Who the Clients Are

Technically, a "case" refers to a child who is receiving services; in reality, the Family Representatives see themselves as working with the whole family. As pointed out in the previous sections, an Indian concept of family does not stop with the nuclear family (mother-father-child[ren] unit), but extends to include a whole constellation of relatives.

Nor is the designation "household" easy to apply to the clients seen at the Center. Since one of the primary functions of the Center is to work with foster placements, many families are divided among several households, i.e., some children may be living in the same

household as their mother, while their brother or sister may be in a foster home. Who, then, shall we count as being part of the "family," and which household size shall we record? Many children seen at the Center have half-siblings, step-siblings, and peer relatives who would be called cousin or aunt/uncle in English, but who are called "brother" or "sister" in traditional cultures. Many live with persons who for practical purposes or by Indian custom are called "mother" or "father," but who may be an aunt/uncle, grandparent, or older cousin in English terminology.

For these reasons, it is very difficult to give an accurate statistical picture of the clients at the Center. Nonetheless, some attempts were made to record demographic information on the children and their families. The particular figures arrived at for each case involve the Family Representative's best judgment about what situation is important for that particular child. In most cases where the child is not in a foster home, the data refer to the household consisting of the child, his/her parent(s), and any children who are considered to be siblings. For children in foster homes, the designation often refers to the size of the household from which the child came. Sometimes, if the foster home is with relatives and is a more or less permanent placement, the constellation of the foster home is used.

Given these qualifications, we can get some idea of the family characteristics that are most relevant to each child. The following

shows the distribution of family size for 191 cases where the data were available:

Family Size	Number of Cases	Percent
1	5	2.6
2	28	14.7
3	55	28.8
4	36	18.8
5	32	16.8
6	14	7.3
7	13	6.8
8 or more	8	4.2

The "families of one" represent emancipated teenagers, that is, youth who have not yet reached age 18 but who are living alone. Thirty-five percent of the children seen at the Center come from families of five or more people, and 54 percent have families of four or more. Although not directly comparable, figures for families in the country as a whole can help put these numbers in perspective.[1] In 1976, the median family size for all families in the U.S. was 3.39, which means that three out of five families (59.6 percent) had three or fewer people. The children at CRC, in other words, come from families considerably larger than the national average.

For 174 cases, a record was made of the employment status for whoever was designated as "head of household." Only 62 (about one-third) of these persons were employed; 76 (43.7 percent) were on welfare, and 36 (20.7 percent) were unemployed. Nationally, 73.4 percent of heads-of-household were employed in 1976--almost three-fourths. The figure for the families at CRC is just over half what it is for Black families below the poverty line (they have an

1. The comparative statistics cited in this portion of the report are computed from tables in U.S. Census (1977).

employment rate of 61.2 percent). Only 4.1 percent of all families in the United States had income which came solely from public assistance, Social Security, and other such income maintenance programs, which means that the Indian families at CRC have a welfare rate over 10 times higher than the national average.

All of these numbers add up to present a picture of large families struggling against urban poverty.

In 158 cases, the age of the mother was recorded. The following shows the distribution:

Age of Mother	Number of Cases	Percent
16-20	14	8.9
21-25	20	12.7
26-30	38	24.1
31-35	30	18.9
36-40	29	18.4
40 +	27	17.1

Over one-fifth (21.6 percent) of the mothers are under 25 years of age, and 8.9 percent of them are teenage mothers. These young mothers are a special concern of the Center, as their needs are particularly acute; many of them are inexperienced single parents.

Over 40 different tribes were specifically mentioned for 113 of the mothers. This distribution reflects the diverse tribal heritage of Indians in the San Francisco Bay Area. The most often mentioned tribe was Sioux (37.2 percent); next were Oklahoma tribes such as Cherokee, Omaha, Creek (15 percent). Navajo made up about 10.6 percent, and the other tribes represented groups from every region in the United States, including Alaska natives.

How They Get to the Center and Why

The initial position taken by CRC staff--and which was evident in the funding proposal--was that there was not much child abuse and neglect, as usually defined by Anglo standards, in the Indian community. What was happening was rather that non-Indians, who did not understand Indian childrearing practices, were incorrectly labeling Indian parents as neglectful and unjustly removing Indian children from their homes. There is a great deal of evidence to support this position, both in Oakland and throughout the country as a whole. (See, for example, AAIA 1977, Center for the Study of Social Welfare 1976, CRC 1977). The process, an indication of institutional abuse, is described in a previous section of this report.

When the Center first opened, it took any and all referrals and acted primarily as a child-advocacy agency with little or no attempt at selectively diagnosing its clientele. This situation is reflected in the results of the evaluation materials collected for the first quarter 1975. All the cases which came through the Center during that period were coded "high risk." The reason for the coding did not reflect a differential diagnosis on the part of staff; rather, since staff were reluctant to apply "abuse," "neglect," or "abuse and neglect" as labels for their clients, they simply took the only other option open to them--"high risk."

An example of such a "high risk" case is the following:

A young Indian family relocated from a reservation to East Oakland. They were not there long when the mother became ill and needed an operation. Because the father was newly employed, he could not miss work and jeopardize the already precarious financial

situation. The father instructed the 9-year-old daughter how to care for the three smaller children, and he left her in charge of them while he went to work. This is acceptable behavior on a reservation where there are extended family members nearby.

On the second day, a neighbor observed that the children were left unattended by an adult, and the police were called. The County Child Protection Service Unit was summoned; since they were unable to learn from the neighbors any facts about the family, they took the children and placed them in County Emergency Foster Homes. The father returned to find his children gone and called the mother. Together they contacted the Child Resource Center for help.

When the Family Representative arrived, needless to say the family was very distraught. The children were in placement a week before the situation could be clarified with the county. When the children were returned, the mother was fearful even to go to the corner store, as she was sure that the police were spying on her for an opportunity to take the children again.

Such a case is, of course, exactly what is meant by a culturally inappropriate diagnosis on the part of non-Indian agency personnel. It is a familiar story to Indian ears and has helped to create the extreme reluctance of Indian families to have any contact with non-Indian social service agencies. The leaders in the field of child abuse and neglect are not unaware of such definitional problems in diagnosing abuse/neglect cases, as indicated by the following citation published by NCCAN:

> Even today, standards of normal and acceptable child care vary by culture and subculture. Practices considered to be mild abuse in some subcultures would in others be completely normal and desirable patterns of childrearing, everyday discipline, or legitimate folk medicine (NCCAN) 1976:3).

However, such cautions are hardly more than lip service paid to "cultural" factors. Experience at the Center has shown that such generalizations are of minimal usefulness, and indeed may produce an effect which is contrary--namely, cases where children are truly in need of help may be ignored in the name of "cultural" variations in childrearing. For example, in the case cited above, what was appropriate on the reservation was potentially harmful in the city where dangers exist that a 9-year-old, especially one unaccustomed to urban survival strategies, is not equipped to handle.

It did not take CRC staff long to realize that their lack of selectivity in accepting clients resulted in a caseload which was humanly impossible to manage. Therefore a decision was made to decrease the scope of services and include only cases of "actual" abuse or neglect. It is still not entirely clear how these definitions are made. Some cases are relatively easy to figure out, such as court referrals where the definition was made by persons outside the Center. These cases account for 1.0 percent of CRC's caseload. Then, there are a very few cases of sexual abuse which no one disputes as deserving of the Center's attention. After all, incest within the nuclear family is a taboo in every culture; there are no crosscultural problems of definition here. But the number in this category is very small--only three have been seen in 3 years--and their identification does not contribute to a culturally specific diagnostic tool.

A look at the characteristics of the families who use the Center's services--their own definition of their problems, the services they are offered, and their experiences--can help in

understanding the types of cases seen at CRC. Such a typology, while not exactly a diagnosis, is nonetheless useful in understanding how the Center works.

As a case comes into the Center, a record is made of the crisis which was reported at the time of referral. The way in which the designation is made is not clear from the records. In some cases, the crisis appears to have been defined by the person or agency making the referral, in some cases by the client, in some cases by the Family Representative, and in some cases by a combination of the above. In the majority of cases, more than one crisis is noted.

Table 1 shows the number of times each category of crisis is reported, either singly or in combination with others, for the 194 cases where the information is available. As can be seen, the kinds of crises most often mentioned are those which involve basic survival needs--namely health, shelter, economic security, and childcare. Two-thirds of the cases are recorded as suffering such a crisis, most of the time in combination with other problems. This finding underscores the multiplicity of needs in urban Indian families and the prevailing lack of resources to meet those needs.

The least mentioned crisis is child abuse, which is recorded for 14.4 percent of the cases. Child neglect is mentioned in 23.2 percent of the cases, putting it in the second-to-last position. Foster placement problems and custody disputes, taken together, account for 66 percent of the crises recorded. Problems with teenagers were reported in one-third of the cases.

Table 1

Type of Crisis Categories Reported
For 194 Cases Seen Before June 1978

Crisis Category	Alone	In Combination With Others	TOTAL	Percent (N=194)
Medical, housing, employment, and/or childcare problems	38	90	128	66.0
Need to arrange or change foster placement	20	62	82	42.3
Teen out of control/runaway	10	52	62	32.0
Dispute over custody	17	29	46	23.7
Child neglect	10	35	45	23.2
Child abuse	7	21	28	14.4

In order to take a closer look at these figures, the categories were collapsed into a single code for each case. Child abuse and/or neglect were singled out first because of the designation of the Center as an abuse/neglect treatment agency. Therefore cases in which abuse/neglect was mentioned were coded as abuse/neglect, regardless of whether other crises were also mentioned. For the remaining cases, problems in foster placement were sorted out next, followed by custody disputes and teen problems. Cases where medical/housing/etc. problems are mentioned alone were coded last. In this way each case became identified by a single crisis-at-referral code.

By looking at these crisis categories in combination with the source of referral, we can gain some clues as to how these categories were arrived at and what such classifications mean for the clients served by the Center. Table II gives the distribution of type of crisis by referral source.

As can be seen from these figures, the overwhelming majority of the cases come from the Indian community itself; only 14.8 percent of the cases were referred by non-Indian agencies or the courts. What seems to happen is something of a consensus from Indians in the community that these are the children who are most in need of help.

Not all the crises reported at the time of referral were found to be accurate descriptions of the problems in the families. For example, in at least 6 of the cases which were labeled abuse/neglect at the time of referral, records indicated that the charges were judged to be unfounded after an official investigation. Furthermore, some families who described their problem as a need for housing or short-term medical care in fact were experiencing severe adjustment problems, and the family was at risk of being dissolved altogether.

Table 2

Crisis at Referral by Source of Referral for 194 Cases

Crisis		Self	Relative or Other Indian	Indian Agency	Non-Indian Agency	Court	Unknown	TOTAL
Child abuse/neglect								
	N	4	8	17	6	2	3	40
	%	10.0	20.0	42.5	15.0	5.0	7.5	100.0
Foster care								
	N	9	5	16	6	2	1	39
	%	23.1	12.8	41.0	15.4	5.3	2.5	100.0
Custody dispute								
	N	11	6	4	0	1	3	25
	%	44.0	24.0	16.0	-	4.0	12.0	100.0
Illness, housing, etc.								
	N	15	14	16	5	0	2	52
	%	28.8	26.9	30.8	9.6	-	3.8	100.0
Runaway, teen problems								
	N	6	2	6	1	6	0	21
	%	28.6	9.5	28.6	4.7	28.6	-	100.0
Other, unknown								
	N	4	3	7	0	0	3	17
	%	23.5	17.6	41.2	-	-	17.6	100.0
TOTAL	N	49	38	66	18	11	12	194
	%	25.2	20.1	34.0	9.2	5.6	6.1	100.0

For these reasons, it is not possible to look at the crisis-at-referral codes as diagnostic categories.

Table 3 shows the distribution of services offered to 194 clients by the crisis-at-referral categories. Most of the cases identified as having an abuse/neglect crisis were given services where the goals were family stabilization or foster placement. Yet nearly two-fifths (38.4 percent) were given services which would indicate that the problem lay in a different area.

These figures help to place CRC and its clientele in an overall community perspective. The clients come to the Center mostly on their own, or because they were referred by Indians. The services thus received are geared toward keeping these families together and providing for basic needs. With this statistical look as background, we can move now to a more detailed descriptive look at CRC families.

Types of Cases

Instead of providing detailed case histories as illustrations of the clients and their problems and as examples of the ways in which the staff at the Center work, it was decided to present a composite case analysis. That is, many case histories were studied and common features were drawn out and compared. This process allows us to see the general patterns in the client families and the underlying patterns of services offered at the Center. At the same time, no individual client can be identified by the presentation of case history data. Thus we can provide clear examples and simultaneously protect the dignity and identity of the clients.

Table 3

Type of Service Offered By Crisis-at-Referral For 194 Cases Closed as of June 1978

Services		Abuse/Neglect	Foster Care	Custody	Illness,etc.	Teen Problems	Other	Unknown	TOTAL[1]
Family stabilization/reunion									
	N	20	9	6	15	5	4	1	50
	%	48.6	23.0	24.0	11.3	23.8	40.0	14.3	25.8
Placement with relatives/Indians									
	N	5	10	6	1	-	-	1	23
	%	12.8	25.6	24.0	1.9	-	-	14.3	11.9
Temp. services									
	N	2	4	-	25	-	-	3	34
	%	5.1	10.4	-	47.2	-	-	42.9	17.5
Referral									
	N	8	5	8	17	4	4	1	47
	%	20.5	12.8	32.0	32.0	19.0	40.0	14.3	24.2
Teen runaway counseling									
	N	3	9	2	-	11	-	1	26
	%	7.7	23.0	8.0	-	52.4	-	14.3	13.4
Other									
	N	2	2	3	4	1	2	-	14
	%	5.1	5.1	12.0	7.5	4.8	20.0	-	7.2
TOTAL	N	40	39	25	52	21	10	7	194
	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

[1]Percentages may not always total 100.0 due to rounding errors.

A composite case history analysis revealed two basic types of client families. These two types, described below, will be used in this section to illustrate the problems which the clients face as they seek help from CRC; in the next section, the types will be used to illustrate how the staff at CRC respond to their clients.

In the first type, which will be referred to as Type A, the parents are at risk of losing their children because they cannot meet their basic physical needs. Usually these families are young, have just arrived from the reservation on Relocation, have few salable job skills and virtually no urban survival strategies in their repertoire.

They are in the city because there are no jobs back home. They often have adequate parenting skills which would be sufficient in a supportive environment such as an extended family household. However, alone in the city they are unable to provide shelter, food, medical care, etc. for their children.

They cannot find work because they have had no adequate education or training in reservation schools. Their already lowered self-image suffers further assaults by the repeated failures in the city, and they are left with little sense of competence or worth. They often do not know how to obtain welfare or subsidized medical care, and are very suspicious of all bureaucratic agencies. They are socially isolated and fearful; tragically, they often see their only alternative to be to turn the responsibility for their children over to someone else. The pressures on this type of family are so acute that without assistance the parents could easily fall into a cycle of despondency, alcoholism, and failure, from which it becomes harder and harder to recover.

The second type of family, Type B, involves parents, usually single mothers, who moved from the reservation when they were children in one of the first Relocation families. These young parents are the victims of the institutional neglect which their parents encountered when they relocated. That is, their parents arrived in the city and faced the problems outlined above for Type A families. They did not receive the help they needed, and the family gradually dissolved.

Usually the parents in CRC's Type B cases were removed from their own parents and placed in non-Indian foster homes. They often were transferred from home to home, usually in families with resources that placed them not far above the poverty line. The children had begun schooling on the reservation, had very poor command of English, and because of this inadequate preparation suffered a cycle of failure in urban schools.

By the time they came to the Center's attention, they had slipped into street life, and their children, who frequently were the results of adolescent pregnancies, had been taken from them. Because their natal families had been disrupted when they were children, and because they had suffered the cultural disruption of the reservation-to-urban shift, they never developed an adequate sense of ethnic or personal identity. Nor did they have an opportunity to develop parenting skills, let alone strategies of responsible self-care.

The children from each of these case types need nurturance, physical care, affection, and a community to belong to. The parents need help in establishing a firm base in the city. For parents in the first type, they need to be pulled into a network which will break through their social isolation and allow them to retain their Indian

childrearing skills. For Type B parents, there is a need to reconstitute what was lost, to relearn the patterns they began with on the reservation.

Summary

What the figures and case history data show is that in a very real sense, a clearly defined differential diagnostic process is not relevant to an Indian model. What seems to be more pertinent is a general recognition on the part of Indians that the children in these families are best served by the Child Resource Center. The implication is that diagnosis is not nearly so important as a division of labor within the Indian community itself. The major variable seems to be whether the child is either already separated from his or her family or at risk of being so. The Center's function, then, is perceived as providing shelter, foster placement, reuniting the family, or coordinating such services. In other words, CRC has assumed a specialized function within the Indian community and performs this function for families where the parent-child bond is in jeopardy.

In summary, then, the people who use the Center come from many tribal backgrounds, tend to have large families, and have few financial and emotional resources. They come asking for help with medical, housing, employment, and childcare problems, as well as help in keeping their families together. More often than not, they come on their own or because an Indian has recommended the Center to them. They fall into two general types which roughly correspond to the generational cycle of urban relocation. Their problems have been generated outside the Indian communities from which they originated, and their life histories document further the effects of institutional abuse and neglect.

V. WHAT THE CENTER DOES

The activities of the various Center staff members will be described in this section. They fall into two general categories: intervention and prevention. Examples and composite case histories will be provided to show in detail the way different parts of the Center function. Throughout, differences between CRC activities and the more familiar non-Indian model will be pointed out.

Intervention

In order to get a closer look at the specific ways in which the Center operates, Family Representatives were asked to use a modified version of the Goal Attainment Guide. This device, developed by Kiresuk (1973), consists of a form which simultaneously acts as a specific case plan and an evaluation instrument. The procedure is to set specific goals for a specific client and then to break each goal into discrete and graduated steps. To be most effective, the goals need to be stated in behavioral terms so that judgments can easily be made as to the progress made by the client.

An example is useful in understanding the process. If the client is out of work and has no salable job skills, a goal may be established to have the client successfully complete a job-training program. The goal can then be broken down into steps such as: client enrolls in program; client attends regularly; client completes assignments satisfactorily; client completes program; client graduates with certification of skill. Each of these steps can be assessed at

different time periods and success in attaining the goal can be measured according to how many steps the client has progressed toward the goal.

For the Family Representatives and their clients, the Goal Attainment Guides were used as case plans. For purposes of understanding the workings of the Center, we can use the sample of Goal Attainments to see what types of case plans were made and how they were carried out. The goals developed for each client were unique to that client's situation. However, an analysis shows that certain patterns were common and appeared in one form or another among several clients' case plans. The following shows the distribution of goal types for a sample of adults in 34 cases which were active in 1978:

Type of Goal		Number	Percent
To provide for financial security and home management.		38	29.0
-obtain training/employment	(18)		
-develop budgeting skills	(9)		
-develop homemaking skills	(6)		
-obtain suitable housing	(5)		
To solve emotional/social problems		35	26.7
-obtain and utilize counseling services	(20)		
-work on specific personal problems	(15)		
To develop responsible parenting skills		30	22.9
-provide appropriate alternate childcare	(14)		
-develop appropriate parent-child interaction skills	(9)		
-obtain and utilize needed medical/legal services	(7)		
To cooperate with foster placement plan		24	18.3
-to work with foster parents	(11)		
-to have child returned	(7)		
-to agree to place child	(6)		
Other		4	3.1
TOTAL		131	100.0

Once again we can see the importance of solving basic urban survival problems (housing, employment, etc.) in these Indian families; nearly three-fifths of the 34 clients (58.8 percent) had these goals set as part of their case plans. These figures point up the failure of such programs as BIA Relocation, which supposedly trains young Indian families in such basic skills. Both Type A and Type B families have these goals in their case plans.

In assisting families to meet these goals, CRC workers utilize the Family Support Network and Homemakers, as well as coordinate vocational training and educational programs in local community colleges and on-the-job sites. Often the "grapevine" is put to work so that jobs and training opportunities especially earmarked for Indians are uncovered.

The second most mentioned category of goals are those which involve the solution of personal emotional and social problems; just over one-fourth (26.7 percent) of the goals were of this type. This type of goal breaks down into two basic classifications. Twenty of them referred to obtaining and utilizing counseling services for personal problems. Most of the time, the services were to be provided by the Family Representatives, although in some cases, the services were to be provided elsewhere (e.g., at a community mental health clinic, a counseling center) and were to be coordinated by the Family Representatives.

The other major classification of goals was to have the clients work on specifically defined problems themselves. In some cases (4), this involved control of drinking behavior. In at least five instances, the goals involved very basic social skills such as

appropriate greeting behavior when someone knocked at the door, or the use of simple "manners" in social interaction. Also included were goals to break through social isolation--to "get out of the house," go places and meet people. In these latter instances, nearly all the cases were from Type B families and involved parents whose behavior had been labeled "neglectful," and whom the Family Representatives described as having very low self-esteem.

Besides providing or arranging counseling, Center activities for the personal problem-solving goals involved providing Homemaker services and linkages with the Family Support Network. The Homemakers would frequently visit in these homes and persistently work on the parents' social skills. They would arrange outings and encourage personal grooming. An important activity would be to bring the parents to the Center-sponsored potlucks so they could meet new people and practice social interaction skills. Some activities such as providing transportation would become settings in which the Homemakers would draw the parents out and help break through the patterns of social isolation.

The development of appropriate parenting skills accounted for 22.9 percent of the goals. Nearly one-half of these (14) were focused on providing appropriate alternate childcare when the parents were absent from the house. The provision of needed medical and legal assistance for the child's benefit was an important category, as was the development of both expressive and instrumental parent-child interaction skills.

In helping to achieve these goals the Family Representatives would assist the families to arrange for medical and legal services,

and the Homemakers would work with the parents in developing parenting skills. Parents were linked up with Family Support Network members, who helped with childcare. The "grapevine" was utilized to help find permanent babysitter services for working mothers, preschool programs, and occasional respite care.

The goals relating to foster placement reveal one of the most unique aspects of the Center's treatment method. Most of the goals mentioned in this classification (11 out of 24) involve cooperating with the foster parents. What this means is that the foster parents and the natural parents were brought together as a unit to work for the benefit of the child.

Whereas most non-Indian programs separate the two families, this Indian model pulls the units together to form one large family group. Frequently after the child has been returned to the natural parents, the unit continues to function as a family, with visits back and forth, help exchanged, advice given.

In a non-Indian model the child becomes something of a pingpong ball, transferred from one family to another and back again. Furthermore, jealousies often arise between the foster parents and the natural parents. Under CRC's model, there is a much reduced chance that such jealousy will arise, since there is a relationship built into the system which continues regardless of whether or not legal custody of the child shifts. These patterns of sharing responsibility for a child have a precedent from tribal traditions, as was pointed out in Section II, so that their utilization in an Indian model is consistent with Indian traditions.

For cases where foster placement is necessary, either because it has been mandated by the courts and child protective services agencies, or because CRC workers have determined that the children in a family need a more secure place to be while their parents are being stabilized, the Center utilizes the Family Support Network and the Indian "grapevine" to find a suitable home. The Indian Nurses of California, who are the sponsoring board for CRC, have formulated a resolution regarding the placement of Indian children, and the staff follow that resolution in making all placements. The resolution sets up a hierarchy of acceptable placements: first, every effort needs to be made to place a child with relatives; if that fails, the next approach is to seek out a family from the same tribal background; if that fails, the child should be placed in an Indian home with a different tribal background. Only when these avenues yield no suitable home is a non-Indian home to be used where the parents are sensitive to Indian issues and in agreement to maintain strong ties to the Indian community.

As was mentioned before, there were no licensed Indian homes before CRC was established. Through the Family Support Network, the Fmily Representatives identify homes, conduct home studies, and assist in processing papers. A sufficient number of Indian homes have been identified so that the Center has been able in nearly every case to place children with relatives or same-tribe families.

Having the child returned represents the last stage in many treatment plans. That is, after the parents have successfully stabilized and are securely linked into the system, then concrete plans are made to return the child. The Family Representatives help

by advocating for the family in court, preparing the child for the move, and securing the necessary legal assistance. The Homemakers often work with the parents in setting up the household and preparing for the child's return.

Prevention

In the area of prevention, an important difference emerges between Indian and non-Indian models. Whereas a non-Indian model emphasizes early identification and intervention with individual clients who are usually labeled "high risk," at CRC prevention activities are directed toward non-Indian agency personnel.

Activities within the non-Indian community primarily involve sensitizing agencies and the general public to the special cultural concerns of Indian children and their families. Included here are explaining childrearing practices which may be mistakenly identified as neglect by non-Indians, providing information on the special legal status of Indians, explaining the inability of the Bureau of Indian Affairs to provide services to an urban Indian population, promoting awareness of such cultural characteristics as a reluctance to seek assistance, and, most important, emphasizing the degree of institutional abuse and neglect which Indians suffer. Very important with regard to this area are staff efforts to explain the extreme reluctance of potential foster families to go through the county licensing process.

Such sensitization is the most powerful preventive measure which CRC staff utilizes. For if non-Indian agency personnel can be made to understand the special needs of Indian children, particularly their

need to be Indian, then future instances of institutional abuse and neglect via removal from home and community can be prevented.

In the early stages of the project, Center staff conducted this sensitization function on a case-by-case basis. This approach was consistent with the initial goal of providing a resource and referral agency. Thus when a case was accepted by the Center, the Family Representatives would contact all other agency personnel--Indian and non-Indian--who were involved in the case. One of the major objectives of such contact was to arrange a case conference in which all the service providers for the client family could come together at the same time and, in the presence of the Family Representative and the client, arrive at a coordinated case plan.

Because of these early efforts at case coordination, Center staff became known on an individual basis to personnel in other agencies. These contacts gradually evolved into an informal network of service providers on whom Family Representatives could rely for assistance and who, in turn, would seek assistance from the Center when an Indian client came to their attention. Eventually, through the sensitization which had occurred during the case conferences, non-Indian agency personnel began to defer more and more to the Center's jurisdiction, and children who might otherwise have been removed from the Indian community were maintained in Indian homes and served by Indian caseworkers.

The sensitization and information flow was not unidirectional. Center staff learned much about the interworkings of county agencies, and through their growing network of sensitive and concerned non-Indian agency personnel were able to learn the non-Indian ropes.

In addition to the informal linkages and case-by-case sensitization, the Center has been funded for a more formal approach to this vital activity. Known as the Training Project, or "Indians in the Urban Setting: A Staff Development Project," it was developed by CRC to provide training and resource information to human service personnel on the political, economic, and psychosocial aspects of urban living for American Indians. Indian and non-Indian teams are being trained to work with public agency personnel in planning and implementing workshops for human service workers in selected Bay Area counties. The Project is being designed as a prototype which can be adapted for use in other urban areas.

The Project consists of three primary elements:

1. Identification, recruitment, and training of Native American trainers.
2. Provision of training services to public service personnel.
3. Updating and dissemination of an Urban Indian Child and Family Service Resource Guide.

Whereas stereotypes of Indian people often prevent human service personnel from seeing the rich diversity that exists among the Native American populace, the Project has noted a willingness on the part of non-Indian human service workers to grow in their understanding of Indian ways. Once made aware of the social etiology, the majority of these workers are eager and willing to improve their abilities at diagnosing, understanding, and aiding their Indian clientele.

One of the main goals in the Project is to increase the training and facilitation skills of Native American resource people, while at the same time providing training for non-Indian human service workers.

Trainers come from Bay Area Indian organizations, interested Indian community members, and students in local Native American Studies programs. Participants in the training to be conducted by these Native American trainers come from a variety of human service agencies, public social services, juvenile justice programs, and mental health facilities.

A second goal is to record the entire process of the Project as it goes on. This recording is being done in order to make the Project available to other Indian organizations who may wish to extend this program to their own urban areas.

A third goal is more long-term: to the extent that the Training Project is successful in promoting change within the service delivery system itself, it will be a major force in preventing future instances of institutional abuse/neglect. In other words, it is attacking an institutional problem by promoting institutional change.

The training is conducted by Indian people according to a curriculum content created by Indian people themselves. The process utilized is one that incorporates both the institutional and individual client perspective surrounding human services. The general questions focused upon are:

1. What do urban agency personnel know about Indian people (e.g., customs, diversity, legal status in regard to human services)?
2. What is it that Indian people <u>want</u> urban agency personnel to know about Indian people?

The initial training efforts have focused on public service agencies serving children (including youth) and families in Alameda

and San Francisco counties. The following schedule is an example of the information which training presents:

Session I	Who are "Urban Indians"?
Session II	Cultural Factors in Human Service Delivery
Session III	The Urban Indian Community Support System
Session IV	Cultural Factors Revisited (Problems and Opportunities)
Session V	Problem Solving and Resource Utilization

Each session is facilitative rather than didactic. Yet informational presentations and printed matter are provided along with group discussion.

The Project has six phases, as follows:

Phase I: Identification and Recruitment of Trainers. Project staff worked with Bay Area Indian oganizations and the Native American Studies Departments of local colleges to identify and recruit Indian resource personnel.

Phase II: Selection of Trainees and Beginning of First Training Cycle. Six to eight trainees will be trained in each of two training cycles. The training includes presentation of material on adult education processes, training methods, design, and evaluation. Initial training involves about 40 hours of presentation and "lab" or simulation work. Each training cycle takes 6 weeks. Sixteen to twenty resource people will be trained in two cycles.

Phase III: Involvement of Target Agencies. Toward the end of the second cycle Project staff work with target agency administrators to create Workshop Planning Committees. The intent is to provide prospective agency participants in training with opportunities to guide Project staff toward as high a degree of relevance as possible.

Phase IV: Implementation of Training. As mentioned earlier, first efforts have focused on child and family service public agencies in Alameda and San Francisco counties. The Project staff wish to "start small" rather than to invest large blocks of time at the onset in multiagency contacts and planning.

Phase V: Assessment, Modification, and Extension. At this stage, Project staff and the Workshop Planning Committees assess the content of training activities. The procedures followed in making agency contacts, planning, scheduling, and supporting training will be analyzed, and proposals will be made for modifications in the program. Whatever changes are decided will be documented as part of the Project's desire to record its efforts.

Phase VI: Extension of Training. The content and schedule will evolve from the interaction of Project staff with Workshop Planning Committees. It is hoped that some of the participants from Phase IV will be available as resource people and advisors during this phase.

Case Studies

Two composite case studies (i.e., put together from several individual cases) have been prepared which can give a complete picture of how all the various parts of the Center are coordinated in a single case plan. One example has been drawn from Type A families and one from Type B.

Type A. A newly arrived family was referred to CRC by another Indian social service agency with a request to find suitable foster placement for the children. The family had no housing and the mother needed medical care. The father was unable to find employment and the family was destitute.

The Family Representative identified a host family from the Family Support Network to provide temporary shelter. Then services were coordinated with other agencies so that the needed medical care was provided. A search for permanent housing was initiated, and the parents were assisted in contacting the local employment office. When the employment office failed to produce a job, the Indian "grapevine" was activated and opportunities were uncovered.

The Homemaker helped the family settle into an apartment and assisted the mother in budgeting and shopping. Where necessary, she provided transportation to and from the clinic, and to and from county agencies to obtain such assistance as food stamps, medicare. During these trips she explained much about what to expect from city life, how to use public tranportation, etc. The children were helped to settle into school; the younger ones were included in the Native American preschool program.

The family was invited to Center-sponsored potlucks, and through the Family Representative and the Indian family which initially provided them with shelter, they were introduced to many other Indian families. A pattern was established so that if the family subsequently suffered a crisis, they would contact the Center or one of the Family Support Network families for help. This pattern was activated when a death in the family meant that the parents needed to return to the reservation temporarily. Help was found in arranging transportation and in providing care for the children while the parents were gone.

The father has stabilized in his job, and the mother's medical problem is under control. Eventually, this family served as "host" for another Type A family, recently arrived.

This case illustrates several elements of the Indian model. The family's initial contact with CRC points up the sense of despair and hopelessness from which many Indian families have learned to view the world. Since they were isolated and without resources, the parents thought that their only alternative was to give their children over to a foster home. Fortunately, they contacted an Indian agency before they contacted County Protective Services.

Another important aspect of this case is the way it illustrates the interdependent nature of the support system. The young family was not exhorted to "make it on its own," but rather was encouraged to remain in the system and ask again for help if it became necessary. This pattern is similar to the tribal expectations of shared responsibilities within the extended kin-group. The fact that the family in turn became a "helper" in the system shows the interrelated strengths of the network.

Type B. A child from a Type B family, who had spent his early years on the streets with his teenage mother, was having severe school problems. His acting-out behavior became so violent that he was to be placed in custody. Due to the linkages which CRC staff had built up with members of the county probation and protective service agencies, an official from the agency contacted CRC before the child was incarcerated.

CRC coordinated a family conference where all the members of the family, mostly young relatives of the mother, were present to decide what to do with the child. The family acknowledged that they did not know how to deal with the child at this time and agreed to foster placement. The Family Representative and the Homemaker carefully prepared the child for moving. The Homemaker especially gave loving and individual attention to him. During the times that she picked him up to provide transportation, she spent extra time with him giving him physical affection, listening to him talk about the things that frightened him, encouraging him to confide in her.

Meanwhile, the Family Representative coordinated services with other agencies which included the school, probation office, protective

services, psychological services, the Indian survival school, and Indian recreation programs. A suitable foster home was found by using links in the Family Support Network. The Family Representative spent much time in preparing the foster parents for the special needs of this child. Counseling sessions were set up, the boy was readmitted to school and also began attending the Indian survival school on a regular basis. A tutor was engaged through CRC auspices and tutoring took place at the Center. Throughout all, the Homemaker spent a great deal of time with the boy--encouraging him to seek comfort from her.

The Family Representative coordinated visits between the boy's family and the foster family. Through the Family Support Network potlucks and events, the Family Representative and the Homemaker gradually drew the boy and his family into the Indian community.

At a recent case conference--coordinated by the Family Representative and attended by the school principal, the lawyer for the family, the placement worker for the county, CRC workers--it was acknowledged that there had been great improvement. The boy no longer acts out at school, is involved with team sports, has steadily improved his grades, and seems to be stabilized.

A "weaning" process began when a new Family Representative took over the case. Due to the new worker's fresh insight, it was seen that CRC's direct involvement in the case could be terminated soon. The boy was carefully prepared for the change in workers and is now being seen at gradually lengthening intervals. The boy and both his families--natural and foster--are still active in the Family Support Network, and that link will be maintained. Eventually, the boy may return to his mother and aunts and uncles; in the meantime his family

of origin and his foster family have formed an extended family. His Indian identity is enhanced and with it his self-image.

One of the points which this case illustrates is the effectiveness of CRC's prevention techniques. The care that had previously been taken to sensitize non-Indian agency personnel was successful in preventing the removal of this Indian child from his culture. The interlocking nature of the whole CRC approach is also apparent in the ways in which the Family Representative, Homemaker, foster parents, and Family Support Network cooperated in pulling the boy and his family into the community.

VI. HOW WELL THE MODEL WORKS

In order to take a look at the effectiveness of the Center's activities, an analysis was made of 194 cases which had come through the Center from June 1975 to June 1978, and which had been terminated from the client rolls. The Family Representative Supervisor, in consultation with the Family Representative assigned to the case, rated each of the cases as to whether or not the outcome was successful. The judgment of success varied depending on the goals of the individual cases; that is, the judgment was based on whether or not the specific services given to a child and his/her family met the particular needs of that family.

A few examples can clarify the process. If a family was in need of temporary services such as medical care and housing, the case was judged to have a successful outcome if such services were in fact obtained. If the family bond was disrupted and a child needed to be placed in a foster home, the case was judged to be successful if the placement was made with an Indian family, and the child was thriving there. If a child was already in foster care and the goals were to reunite the family, the case was judged to be successful if the reunion took place and the family situation stabilized.

Overall, the Center was successful in 61.3 percent of the cases. Given the severity of the problems from which the Indian clients at CRC have suffered, such a rate is impressive indeed.

In order to get a closer look at this measure of CRC's impact on clients, the outcome rating was compared to the crisis-at-referral category. Table 4 shows the distribution. In those cases in which abuse/neglect was listed as a crisis, nearly two-thirds were rated as successfully resolved. Of course, as was noted in Section IV, the crisis-at-referral code cannot be assumed to be an actual diagnosis of abuse/neglect. Similarly, cases which did in fact involve abuse/neglect may have appeared on the Center's rolls with a different presenting problem. Overall, however, it is safe to conclude that the Center's treatment model worked for the majority of abuse/neglect cases which it handled.

Table 5 shows the distribution of cases by outcome and type of service offered to the clients. As can be seen, CRC is differentially effective in its service provision. The highest rate of success is with services designed to place children successfully and/or stabilize a family. Nearly four-fifths of the cases receiving these services were judged successful. Since the objective of this service type is the major goal of the Center itself, we can conclude that CRC has demonstrated its effectiveness.

The least effective services appear to be those rendered to teenagers (38.5 percent). Just over one-half of the referral services proved effective, while nearly three-fourths of the temporary services were successfully accomplished.

Tables 6 through 9 present a more detailed look at these results. From an analysis of them, we can draw some implications about the Center and its treatment model.

It appears from Table 6 that it was somewhat easier to place a child successfully than it was to stabilize a family. Nonetheless, in the over seven out of ten cases, CRC was successful in stabilizing Indian families.

Table 7 seems to indicate that emergency housing is a relatively difficult service to provide. Of course, the numbers are very small in this category--only a total of 14 cases are available; nonetheless, it may be that more effort should be generated through the Family Support Network to find emergency housing for Indian families and/or that special funds be provided to cover suitable rental facilities.

From Table 8, it would appear that medical services are the easiest to coordinate successfully, while referrals to non-Indian agencies can present followup problems. As prevention and sensitization activities continue, this situation may improve.

Table 9 shows the category in which the Center was least effective, namely, providing services to adolescents. CRC staff have been aware of this situation for some time. They see the young people as needing far more than the resources of the Center can accommodate. The Center has repeatedly attempted to obtain special funding to build programs for these teenagers. The basic need, as they see it, is for a residential treatment center--a place where youth can live in a supportive setting and not be swallowed up in the urban ghetto streets. As yet, the requests for a proposed group home or a residential program for teenage parents have not been honored.

The overall conclusion to be drawn from these figures is that the Indian model has proved itself as an effective treatment approach. What fits together is a logical system--from etiology through intervention--which also appears to work for real people with real problems.

Table 4

Distribution of Closed Cases By
Crisis at Referral and Outcome

Crisis at Referral		Outcome: Successful	Outcome: Unsuccessful	Outcome: Unknown	TOTAL [1]
Child abuse/neglect					
	N	26	7	7	40
	%	65.0	17.5	17.5	100.0
Foster care; placement					
	N	21	11	7	39
	%	53.8	28.2	17.9	100.0
Custody dispute					
	N	12	8	5	25
	%	48.0	32.0	20.0	100.0
Illness,housing,etc.					
	N	36	6	10	52
	%	69.2	11.5	19.2	100.0
Runaway,teen problems					
	N	14	3	4	21
	%	66.7	14.3	19.0	100.0
Other, unknown					
	N	10	5	2	17
	%	58.8	29.4	11.8	100.0
TOTAL	N	119	40	35	194
	%	61.3	20.6	18.0	100.0

[1] Percentage may not always total 100.0 due to rounding errors.

Table 5

Distribution of Closed Cases By
Type of Service and Outcome

Type of Service		Outcome: Successful	Outcome: Unsuccessful	Outcome: Unknown	TOTAL [1]
Placements, family stabilization					
	N	57	12	5	74
	%	77.0	16.2	6.8	100.0
Temp./short-term					
	N	25	6	3	34
	%	73.5	17.6	8.8	100.0
Referral/resource coordination					
	N	26	7	14	47
	%	55.4	14.9	29.8	100.0
Services to adolescents					
	N	10	12	4	26
	%	38.5	46.2	15.4	100.0
Unknown					
	N	1	3	9	13
	%	7.7	23.1	69.2	100.0
TOTAL	N	119	40	35	194
	%	61.3	20.6	18.0	100.0

[1] Percentages may not always total 100.0 due to rounding errors.

Table 6

Distribution of Closed Cases Involving
Placement and/or Family Stabilization By Outcome

Type of Service		Outcome: Successful	Unsuccessful	Unknown	TOTAL [1]
Family stabilization;[2] reunion					
	N	37	10	4	51
	%	72.5	19.6	7.8	100.0
Placement with relatives/Indians[3]					
	N	20	2	1	23
	%	86.9	8.7	4.3	100.0
TOTAL	N	57	12	5	74
	%	77.0	16.2	6.8	100.0

[1] Percentages may not always total 100.0 because of rounding errors.

[2] Includes cases where family was stabilized before child was removed and where child was reunited with family after the family was stabilized. Includes 5 cases returned to the reservation.

[3] Includes placement within the Bay Area as well as cases (8) where child was returned to reservation.

Table 7

Distribution of Closed Cases Involving
Short-Term Services By Outcome

Type of Service		Outcome: Successful	Outcome: Unsuccessful	Outcome: Unknown	TOTAL [1]
Emergency placement					
	N	7	-	-	7
	%	100.0	-	-	100.0
Homemaking; childcare					
	N	11	2	-	13
	%	84.6	15.4	-	100.0
Emergency housing					
	N	7	4	3	14
	%	50.0	28.6	8.8	100.0
TOTAL	N	25	6	3	34
	%	73.5	17.6	8.8	100.0

[1] Percentages may not always total 100.0 due to rounding errors.

Table 8

Distribution of Closed Cases Involving
Referral and Resource Coordination By Outcome

Type of Referral		Outcome: Successful	Outcome: Unsuccessful	Outcome: Unknown	TOTAL [1]
To Indian agency					
	N	6	3	3	12
	%	60.0	25.0	25.0	100.0
To non-Indian agency					
	N	2	-	7	9
	%	22.2	-	77.9	100.0
To medical facility					
	N	11	1	-	12
	%	91.7	8.3	-	100.0
To legal assistance					
	N	4	3	1	8
	%	50.0	37.5	12.5	100.0
Other					
	N	3	-	3	6
	%	50.0	-	50.0	100.0
TOTAL	N	26	7	14	47
	%	55.4	14.9	29.8	100.0

[1]Percentages may not always total 100.0 due to rounding errors.

Table 9

Distribution of Closed Cases Involving Services to Adolescents By Outcome

Type of Service		Outcome: Successful	Outcome: Unsuccessful	Outcome: Unknown	TOTAL [1]
Group home/BIA school enrollment					
	N	4	5	1	10
	%	40.0	50.0	10.0	100.0
Returning runaway					
	N	3	1	3	7
	%	42.9	14.3	42.9	100.0
Delinquency counseling					
	N	3	6	-	9
	%	33.3	66.7		100.0
TOTAL	N	10	12	4	26
	%	38.5	46.2	15.4	100.0

[1] Percentages may not always total 100.0 due to rounding errors.

VII. OTHER SETTINGS, OTHER PROGRAMS

In this section of the report comparisons will be drawn between Oakland's Urban Indian Child Resource Center and other Native American programs funded by the National Center on Child Abuse and Neglect (NCCAN). The information in this section comes from site visits to three of the projects--the Child Advocacy Program, sponsored by the Mississippi band of Choctaw Indians; Child Abuse and Neglect Program, sponsored by the Cook Inlet Native Association in Anchorage, Alaska; and Ah-Be-No-Gee, sponsored by the University of Minnesota in Minneapolis. In addition, interviews were conducted with staff members from those programs as well as with persons from Ku-Nak-We-Sha sponsored by the Confederated Tribes and Band of the Yakima Indian Nation in Washington state. Reports prepared by the official evaluation team from CPI Associates were reviewed as well as reports prepared by project staff members.

The data thus gathered have been analyzed to discover principles for child abuse/neglect and family service programs which may be common in most Native American settings. The results, reported in the following pages, show that the experiences at Oakland's Urban Indian Child Resource Center are not unique in the Indian world.

One of the most important similarities among all the Native American programs is their view of etiology as institutional in origin. They all point to the tendency of non-Indian agencies to remove Indian children from their homes at higher rates than non-Indians, to the institutional neglect suffered by Indian families who are not provided with appropriate services, to the systematic ways in which Indian children are denied culturally relevant education, to the destruction of Indian life styles by encroaching non-Indian political and economic interests. All programs had as one of their primary goals to stop the removal of Indian children from their homes and culture and to preserve Indian family life.

All the projects rely on traditional Indian family and social organization as the most powerful intervention tool available for Indian children and their families where the family bond is in danger of being dissolved. Each of the programs includes a concept similar to the Center's Family Support Network to draw families into the larger Indian community, to build tribal and ethnic identity, and to protect children from removal from their homes and heritage. In the urban areas, Minneapolis, Anchorage, and Oakland, there is the additional use of the network as a source of urban survival skills for newly arrived migrants.

Most programs share with CRC a reliance on social events as a basic treatment method. Potlucks, feast, giveaways, powwows, are part and parcel of an Indian approach to the delivery of human services. The atmosphere of a social gathering, especially when bolstered by ceremonial events and rites, gives poignancy and validity to the family/social-network treatment model. Personal egalitarian

interacting by all persons--workers, clients, others--is the key characteristic.

It is instructive to note the growing interest among Anglo professionals in such concepts as "natural helping systems," "network therapy," "social support networks." What has happened among the Native American programs is the implementation of such approaches in a fully articulated model. Whether or not Anglo-run institutions can identify and incorporate a "natural helping system" into a model which has individual pathology as an etiological base and individual independence as a treatment goal, is problematic. What makes a natural system "helping" is its very personal approach to someone in need and its interdependent linkages. It is difficult to conceive of workers in an Anglo institution abandoning their professional distance and allowing themselves to be helped by their clients. Yet, these are the implications of a helping system where the interconnections are reciprocal in nature.

In maintaining and enhancing the families' links with the tribal or surrogate extended-kin network, each of the programs depend upon older women who have positions and roles similar to those of CRC's Homemakers. It is imperative that these women be very close to the clients of the centers in social status and personal background. It is also imperative that they have the respect of age and experience in successfully raising children and launching them into the Indian as well as the non-Indian world. Often these women have special knowledge of traditional healing or healers, and thus form a kind of lifeline to spiritual guidance. They are surrogate grandmothers with warm bosoms and caring souls.

The caseworkers, those who fill the roles filled by the Family Representatives at CRC, are usually Indian. This fact is very important in understanding much about what all these projects have in common. For, the actual face-to-face work with Indian clients is usually in the hands of Indian caseworkers. Occasionally non-Indian MSWs, psychologists, counselors are brought into the case plan, but almost all the time this happens in order to provide back-up and assistance to the Indian caseworkers. The most frequent situation is that the non-Indians do not see clients themselves, but work with the workers, training them in their expertise and assisting in putting together case plans which the Indian workers then implement. The result of this approach is that the Indian caseworkers get a kind of intense on-the-job training while their clients receive the benefit of professional expertise as delivered by Indians to Indians.

This pattern of putting non-Indian personnel in an advisor or employee status vis-a-vis Indian programs, is one of the most visible forms of institutional change that the projects have produced. For the non-Indians occupying these positions, there is frequently a special kind of "burn-out" syndrome. Usually such persons are accustomed, by culture and training, to be in control of their own labor and expertise. In times of conflict between their professional experience and Indian priorities, they can be faced with an unfamiliar sense of impotence and frustration.

In almost every program there is a person, usually a woman, who occupies a very special role in the program's effectiveness. This woman--sometimes the project director, sometimes the person who in an non-Indian model would be seen as the second-in-command, sometimes

another staff member--is the "glue" which holds the project together. She has the following qualities: she is plugged into and central to the "grapevine"; she is respected--sometimes reluctantly--by all factions in the Indian community; she has an undying belief in the value of what she is doing for Indian children; she has an ability to smooth over intratribal or intra-community rivalries; she has a trust in all her staff even when they understandably begin to doubt themselves; she works harder than anybody else but not because she means to show anybody up--she does this because to her this work is her life's blood; she has something which objective forms of analysis know very little about--she has charisma. Her staff and the non-Indians with whom she has contact say such things as the following when they describe her: "I feel a warmth when I am near her," "She always has something nice to say about everyone even people who disagree with her," "I always work harder when she says she knows I can do something," "God, is she an optimist!"

The qualities which she possesses are probably not amenable to training. That is, until we know much more than we do about socialization and personality development, we can probably not incoporate education for charisma into any of our courses on casework, counseling or behavior in the helping professions. What we can learn to do, however, is to recognize these qualities in individuals and make sure that any Indian program has a person like this on staff.

The position of Director differed somewhat among the projects. Most of the time that person was Indian, usually working under an Indian Board or Indian tribe. In those cases where the person was non-Indian it was clear that they were sensitized to Indian issues and

conceived of themselves as being in the employ of, and working at the pleasure of, Indian people. However, being either a non-Indian Director or an Indian with a strong professional identity lead to strains in some cases. The pull between the Indian and non-Indian model was very strong in these cases and sometimes created severe breaches.

Most of the projects have split the functions of internal management and administration on the one hand, and representation of the program to the outside non-Indian world on the other. The persons performing the latter function have become very sophisticated in manipulating public relations and political support in order to maintain the resources they need to keep the programs running. Usually the people who write proposals, attend conferences, travel to workshops, serve on committees, are not the same ones who provide direct services and supervise internal operations.

To be effective, this separation of function needs to be carefully balanced. A tip in either direction can produce disastrous results. In the interests of increasing funding, precious resources can be over committed by a fundraiser who is not in touch with shifts in daily operation. Concentration on internal problems to the exclusion of shifts in external politics and funding priorities can leave the program with no resources to carry on its services.

Recognizing these problems, Oakland's CRC has made a deliberate effort to involve many direct service staff members in a variety of public relations and policy-oriented activities. In this way, the functions remain split but more people within the Center can learn to perform both so that neither function resides solely in the hands of one person.

The nature of the sponsoring agency of the various projects differed. For the rural or reservation-based projects, the Tribe was the Board of Directors. In Urban areas some other solution was necessary. In two urban programs, an Indian or Native board was the sponsor; in one, it was a university. To the degree that the university allowed autonomy to its Native American component, the functions were the same. For both kinds of sponsorship, there was always the very real problem of intratribal and intracommunity politics to contend with. Competing priorities and competing pressures for support often demanded so much of staff effort that the running of the program itself was threatened.

In reservation areas the tribes themselves were often buffeted by jurisdictional disputes arising from treaty law, county law, state territorial aggrandizement, and an unbelievable tangle of bureaucratic and departmental paper-shuffling. These problems, familiar to anyone versed in Indian history, only point up again the insidious and consistent pressures of insititutional abuse suffered by Native peoples. For, more often than not, it is not they who define their territory and ethnic identity, but rather Anglo governments and agencies each jealous of its own jurisdiction and sphere of influence. In the case of the Choctaw especially, these intergovernmental disputes among Anglo institutions were particularly devasting to the project.

The children and families who receive services in the various projects have much in common with each other. They are usually from young families where institutional abuse has rendered them economically destitute. There are some differences between

reservation-based and urban projects which are important. For the reservation areas, tribal and ethnic affiliation is a more clearly identifiable concept. The city has people from many tribes, many cultures, many languages. For persons from smaller tribes, it is difficult to find someone who shares one's traditions or language. Intermarriage produces children of mixed heritage--"hyphenated" Indians, as they are sometimes called. All of these things make building ethnic identity a difficult process.

Yet, while reservation programs can more easily call on still-existing social organizations and traditions, they usually have fewer economic resources to work with than their urban counterparts. The city has more and higher-paying jobs and a wider range of available services which can be manipulated more flexibly than rural-based ones can.

It is nonetheless true that the relative economic advantage of the urban setting is just that: relative. As was pointed out in Section II of this report, making it in the city is a very precarious proposition. The strong need for tribal identity often pulls urban migrants back to the reservation. The result is a revolving-door pattern with frequent moves to and from the city. Therefore, chances are that some of the people seen at urban centers are also the same people who seek services in reservation programs. Until the institutional abuse/neglect problems are solved, this pattern is likely to continue for a certain segment of the Indian population.

Summary

In summary then, it is apparent that despite the variations due to location and tribal diversity, there are more areas of similarity than differences among Native American child abuse/neglect programs. The Indian model, as seen in each of them, includes the etiological concept of institutional abuse/neglect, a family/social-network treatment approach, an understanding and reliance on personal qualities of key staff, and utilization of non-Indians as supplementary and advisory personnel. To the extent that the programs have maintained their autonomy from outside legal and bureaucratic encroachments, they have been able to maintain and enhance their services. Where such outside pressures have been greater than the program's ability t_ resist, the cycle of institutional abuse has begun again, and the program's future has been put in jeopardy.

VIII. RECOMMENDATIONS

The experience gained at Oakland's Urban Indian Child Resource Center and at the other NCCAN-funded innovative Native American programs can stand as a model for other child abuse/neglect treatment centers designed to serve Indian people. This section of the report offers specific recommendations which are judged to be most important in overcoming the institutional abuse and neglect which have caused a disruption in the parent-child bond among Native American families.

1. Control of Indian programs must be in the hands of Indians.

This principle cannot be overemphasized. It will not suffice to have a non-Indian agency hire Indian staff or put together an Indian advisory committee. These attempts to provide "culturally relevant" services or "input" from the community do nothing to change the institutional basis of the problem. When control and authority shift into Indian hands, then institutional change has occurred. Unless that happens, a service provider--Indian or non-Indian--no matter how sensitive and well-intentioned, is still in the employ of a non-Indian institution. In case of a conflict between the agency requirements and Indian priorities, such a person or group has no recourse but to follow the institution's policies.

As has been pointed out in this report, non-Indian experts and "helpers" often play very important part in Indian-controlled programs. They provide professional expertise and knowledge of bureaucratic regulations. They can train staff, provide links with the non-Indian power structure, help seek funding, and act as translators between the two systems. But they should only perform these functions for Indian programs as advisors or employees, never as directors or employers.

2. Utilization of tribally based family structure and communal events are the most effective basis for treatment.

Non-Indian treatment models rarely involve the client's community--that network of family and friends within which the client moves. Individuals from that network may come into the treatment plan, but usually as persons to be adjusted to, separated from, or coped with. Given theories which assume that individual pathologies are due to individual variations in development, such intervention techniques make sense.

However, in an Indian setting, the assumption is that pathologies develop from institutional causes and affect cultural patterns. Therefore treatment must involve patterned networks and shared systems of values. Native families--broken by outside interference--need to be reconstituted as Native families. Opportunities to reestablish a damaged ethnic identity can break patterns of social isolation and help to provide hope to those who have had it taken from them. The opportunities for such reconstitution and reestablishment of ethnicity are to be found in the extended-kin networks and ceremonial events of tribal origins.

3. Indian treatment models need to avoid pressure toward "professionalism" which separate therapy from other services.

Support services are usually defined in an Anglo system as those services which are not directly linked to treatment or intervention, but rather facilitate or provide access to treatment. In an Indian model no such distinction is made. Services such as homemaking, transportation, childcare, emergency shelter, are considered to be as much a part of treatment as therapy or counseling. Given the concept of etiology as institutionally or systemically based, such a perspective makes sense. That is, if etiology involves disruption at an institutional level--e.g., disruption of a family system or a whole tribal lifestyle--then appropriate intervention must also be institutionally based. The objective then is not to patch up individuals but rather to reconstitute whole families as social units.

Therefore treatment must function as a whole system with each part equally important and inexorably interlocked. Homemakers, for example, become part of a new social unit and their services are integral to good treatment, as opposed to auxiliary. Since the objective is to rebuild a family system, the homemaker represents a part of the new family. She is there to provide a direct and visible link to the new social network. When a client utilizes her services, it constitutes a decrease in social isolation and a reorientation to the tribally based extended family system.

A similar analysis can be made of the way transportation, emergency shelter, and childcare are utilized in an Indian program. The importance of these elements in pulling a client--parent and/or child--into the larger Indian community cannot be overemphasized.

4. Treatment goals must emphasize a transition from dependency to interdependency.

Most Anglo models of treatment aim for independence, "standing on one's own feet." Such goals are consistent in a model which views etiology as individually-based and due to abnormal processes in personal socialization. However, etiology which is institutionally anchored demands a view of a healthy person as an integral part of a social network. That means that interconnections among individuals make up the ultimate goal of socialization. People in an Indian model are not seen as emerging as individuals or independent units, but as members of a mutually reinforcing community.

Just as in tribal antecedents, young parents were not expected to shoulder the responsibility of childrearing alone, so clients in Indian treatment programs are not expected to assume sole responsibility for their childrearing skills. In return for help when they need it, they are expected to contribute support to others somewhere else in the system. The system as a whole can then maintain itself and enhance its resources.

5. The administrative structure needs to be interdependent and nonhierarchical.

In a non-Indian model, authority and responsibility are the prerogatives of persons or groups who are viewed as being in command. To advance in such a system is to be rewarded with new vestiges of authority and to assume new areas of responsibility. Just as the goals of treatment are to be independent, to assume individually responsible action, so are the goals of professional advancement to amass more authority and individual rights to decision-making.

An Indian model is based on a non-hierarchical structure where decision-making is consensual. Responsibility is thus shared. This principle applies at all levels so that maintaining "professional distance" is less important than linking into a mutually supportive, interlocking network.

6. Prevention needs to be aimed at non-Indians.

Prevention in a non-Indian model usually involves community awareness campaigns to help citizens identify early signs of abuse/neglect. There is a parallel in an Indian model, except the "community" to whom the campaign is geared is the community of non-Indian agency personnel. These are the people who need to be made aware of the early signs of institutional abuse/neglect. Through sensitization, they can learn to halt its destructive effects on Indian children and their families.

7. Funding needs to be provided in such a way that a secure resource base is available.

It is a simple fact of economic life in the United States that Indians have fewer financial resources than any other group. Anglo-run programs have far greater chances of securing funding through the institutions which they control and the communities which they serve, than do non-Anglo programs, especially Native American ones. The only real way to reverse the effects of institutional abuse/neglect on Indian people is to provide Indian programs with secure and sufficient funding to continue their services free from the fear of financial defeat.

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